if resources for palliative care services are spread more equitably between cancer and non-malignant disease will our long-suffering patients with COPD and heart failure be given the care their symptoms deserve.

Rupert Jones
Respiratory Research Unit, Peninsular Medical School, Universities of Exeter and Plymouth. E-mail: rupert.jones@pms.ac.uk

REFERENCES

1. McKinley RK, Stokes T, Exley C, Field D. Care of people dying with malignant and cardiorespiratory disease in general practice. *Br J Gen Pract* 2004; **54:** 909–913.
2. Lehman R. How long can I go on like this? Dying from cardiorespiratory disease. *Br J Gen Pract* 2004; **54:** 892–893.
3. Gore JM, Brophy CJ, Greenstone MA. How well do we care for patients with end stage chronic obstructive pulmonary disease (COPD)? A comparison of palliative care and quality of life in COPD and lung cancer. *Thorax* 2000; **55:** 1000–1006.
4. Jennings AL, Davies AN, Higgins JP, *et al.* A systematic review of the use of opioids in the management of dyspnoea. *Thorax* 2002; **57:** 939–944.
5. National Institute for Clinical Excellence. *CG12 Chronic Obstructive Pulmonary Disease Clinical Guidelines.* London: Abba Litho Ltd, 2004.
6. British Thoracic Society Standards of Care Subcommittee on Pulmonary Rehabilitation. Pulmonary rehabilitation. *Thorax* 2001; **56:** 827–34.

Bad language

Having lambasted you for years for your abuse of English, I am delighted to see recent signs of improvement. I am now able to read the journal from front to back without hurling it from me in disgust at yet another issue (note: correct use of that word) full of mangled verbiage. And more! Better still, you have a list of banned words! I am so pleased to see this and would like to add a few more. Firstly, 'issue' is grossly overused but I suspect it is beyond resuscitation. Secondly, 'within' is a classic example of using a longer word when a shorter one ('in') is perfectly adequate and to my cortex at least, much more suitable.

Finally, 'around' is set to be the horrendoma of the decade for any of us who like our English wrote proper. Issues around the use of language within the editorial team, for example. Do I have to translate that one into plain English?

So please, be encouraged by praise from one of your sternest critics and keep up the good work!

Declan Fox
Freelance physician, Newtownstewart, County Tyrone.
E-mail: declan@boskone.freeserve.co.uk

Injecting drug users

As the study by Tompkins *et al*[1] highlights, many injecting drug users receive less than adequate care with regard to hepatitis C virus (HCV) testing and follow up. In response to this situation, an innovative model of care has been developed between Nottingham City Hospital and an inner city GP surgery.

The practice provides enhanced GMS /PMS to an unselected population of substance misusers — many of who are homeless, currently numbering 212 per year. Five doctors have completed the RCGP Certificate, and with support from specialist drug treatment workers work to agreed Shared Care Protocols. Retention in treatment is at the 75% level at 1 year.

Hepatitis testing is offered to all, either serum or buccal depending on ease of obtaining samples. An initial audit of our cohort revealed that the prevalence of HCV infection among 174 currently active clients is 47%, 72% of whom have not been polymerase chain reaction tested. Only one previous patient has been successfully treated with pegylated interferon and ribavirin. Hospital non-attendance rates in Nottingham for hepatitis C clinics are approximately 15–40% (M Holiday and M Nicholls, personal communication, April 2005) and only 11 of our cohort have been seen in secondary care. The highest risk group for new infections are injecting drug users who share among themselves, and mathematical modelling indicates that behavioural interventions may have only a limited effect.[2] Therefore, the most effective way of reducing the endemic prevalence may be to treat those infected with pegylated interferon and ribavirin,[2] in order to reduce the pool of infection that can be transmitted.

Our model of care aims to transpose a hospital hepatitis C service directly into the heart of a community of vulnerable clients, by employing a nurse specialist to undertake caseload management. The three main elements are: to identify new cases of HCV infection by actively testing clients with risk factors; to offer pegylated interferon and ribavirin to clients who would not attend a hospital clinic; and to facilitate a consultant review of clients with obvious evidence of cirrhosis. In addition, the cohort provides real world data on the natural history of HCV infection in injecting drug users that is essential for decision making,[3] and we can measure how the efficacy of pegylated interferon and ribavirin translates into successfully treating injecting drug users.[3]

Treating current injecting drug users may be controversial, but our goal is to facilitate equity of health care and improve the long-term public health of an impoverished and marginalised community.

Kate Jack
Hepatitis Nurse Specialist, Nottingham.
E-mail: kate.jack@gp-c84683.nhs.uk

Michael Varnam
General Practitioner, Nottingham

Brian Thomson
Consultant in Infectious Diseases, Nottingham

REFERENCES

1. Tompkins C, Wright NMJ, Jones L. Impact of a positive hepatitis C diagnosis on homeless injecting drug users: a qualitative study. *Br J Gen Pract* 2005; 55: 263–268.
2. Kretzschmar M, Wiessing L. Modelling the transmission of hepatitis C in injecting drug users. In: *Hepatitis C and injecting drug use: impact, costs and policy options. Monograph 7.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2004.
3. Gurwitz JH, Sykora K, Mamdani M, *et al.* Reader's guide to critical appraisal of cohort studies: 1. Role and design. *BMJ* 2005; 330: 895–897.

The RCGP Council: a worm's eye view

I was recently honoured by the College. Not with a gong or a fellowship but by an invitation to vote in the Election of Members of College Council 2005–2008. I was instructed to read the Candidates' Statements first and, of course, could not refuse. The 12 candidates (I cannot call them the Baker's dozen as the Honorary Secretary only nominated two) were a

strikingly experienced and talented bunch. Among them there were three professors, a past GPC chair, chairs of Council, JCPTGP chairs and a veritable smorgasbord of present Council members and GMC and RCGP examiners. Yet despite this, humility was evident. One candidate either chairs or is a member of 17 committees and yet described himself as an 'ordinary' GP. I'll show you ordinary mate. After reading this I felt less like a grass roots member and more like a worm within. This member once attended a faculty annual lecture and … well, that's been it. I was rather despondent at the energy, talent and contribution of others, but relieved that such greatness speaks for my profession and me. But how representative are these worthies? Only one practises in my country, that being 60 miles as the crow flies (a worrying expression for a worm) and the youngest is 10 years my senior. I know of several members who have felt as close to the College as they do to an orbiting planet and exchanged their College subscriptions for that of a wine club. Could the College and Council be more inclusive and representative? It's not for me to say, but meanwhile I'll continue to enjoy the Journal (the second half anyway) and to exercise my vote.

David Carvel
General Practitioner, Biggar Health Centre, South Lanarkshire.
E-mail: david.carvel@lanarkshire.scot.nhs.uk

The Chairman's response can be found on page 480.

Advance directives: awareness in care homes

Advance directives are statements recorded by a competent individual containing information on health-related values and choices. They seek to extend the individuals' autonomy in anticipation of events that would subsequently compromise their ability to express themselves. Advance directives are likely to be particularly relevant to care home residents, who are may have prior experience of serious illness. We undertook a postal questionnaire survey of all managers of care homes in Leicestershire to determine their attitudes towards advance directives (Table 1), as care home managers would have a key role in facilitating advance directives for care home residents.

Table 1. Replies from a survey of Leicestershire care home managers on end-of-life care.

	Residential homes *n* = 199	Dual registered homes *n* = 44	Combined *n* = 243
Have you heard of advance directives?	47 (24%)	22 (50%)	69 (28%)
Does your home have a policy on advance directives?	10 (5%)	7 (16%)	17 (7%)
Have you heard of 'do not resuscitate orders'?	137 (69%)	38 (86%)	175 (72%)
Does your home have a policy on the resuscitation of clients?	72 (36%)	18 (41%)	90 (37%)

Seven homes were no longer operational and two homes declined to participate. Of the remaining homes, 243/391 (62%) returned the questionnaire. Overall, 67% of the homes cared for older clients and 41% catered for people with physical disabilities. Of those homes with a policy on advance directives or resuscitation, 16/95 (17%) discussed end-of-life care routinely with their clients; 22 (23%) when their clients became unwell; 37 (39%) when prompted by other healthcare professionals; and 24 (22%) discussed end-of-life care if requested by the client. Further information on end-of-life care was requested by 171/243 homes.

This is the first UK study examining the attitudes of care home staff towards end-of-life care for their clients. Awareness of advance directives was relatively low (28%) compared to awareness of DNR orders (72%), but higher in nursing homes compared to residential homes in both cases. The timing of end-of-life discussions suggested by this survey suggests a more reactive rather than a proactive approach. Weaknesses of the study include that we were unable to verify that responses reflect actual practice and whether the responders were indeed representative of the larger population of care home managers.

The North American experience of advance directives suggests that they can improve client care and reduce costs, when used systematically and in the context of a broader end-of-life managed care programme.[1,2] The circumstances in the UK are coming together to facilitate the introduction of advance directives. The mental capacity bill provides the legislative framework and case management will provide the opportunity. What is not known, are the barriers that exist within the medical profession and the health service more generally, that will inhibit greater use of advance directives.

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Simon Conroy
Clinical Lecturer in Geriatrics, Queen's Medical Centre, Nottingham.
E-mail: simon.conroy@nottingham.ac.uk

Su Kiun Chin
Specialist Registrar, Department of Medicine, Queen Elizabeth Hospital, Sabah, Malaysia

Nelson Lo
Consultant Physician, Leicester General Hospital, Leicester

REFERENCES

1. Molloy DW, Guyatt GH, Russo R, *et al.* Systematic implementation of an advance directive program in nursing homes: a randomized controlled trial. *JAMA* 2000, **283(102):** 1437–1444.
2. Teno JM. Advance directives: time to move on. *Ann Intern Med* 2004, **141(7):** 159–160.